COUNTY CORE SERVICES

County funding of services is provided primarily in three categories:

- Commitment/Institutional Services: mandated, statewide availability and eligibility
- Medicaid Match Services: mandated, statewide availability and eligibility
- 100% County Funded Services: defined by County Management Plan, local availability and eligibility determination

COMMITMENT/INSTITUTIONAL SERVICES

Certain involuntary commitment and other institutional services are provided in accordance with Iowa Code Ch. 229, Code Ch. 222 and other applicable Iowa Code language. These services are generally involuntary and are provided pursuant to an order of the District Court.

No financial eligibility guidelines apply, however, statutory liability may apply. Consumer liability for commitment related services is determined according to the provisions as allowed by the Iowa Code.

All residents will be considered to meet the diagnostic criteria of MI for involuntary mental health actions and ID for involuntary mental retardation actions if no other covered diagnosis is applicable, for these court ordered services.

Services:
Diagnostic Evaluation Related to Commitment
Sheriff Transportation
Legal Representation
Hospitalization (48-Hr Emergency Hold, 229 5-day Evaluation, Treatment after hearing – Court Ordered)
Mental Health Institute
Mental Health Advocate
Iowa Medical Classification Center (Oakdale)

The above applicable services may also be provided for commitments under Ch. 222 relating to mental retardation. NOTE: CH 222, involuntary mental retardation actions, are extremely rare.

MEDICAID MATCH SERVICES

Medicaid Match services are those services for which counties provide payment of the non-federal share of a Medicaid payment. These services are available only to those persons who are Medicaid eligible.

Persons who are determined eligible through the Medicaid process are considered eligible for Medicaid Match funding. The determination of required diagnosis is made during the Case Management process in accordance with Medicaid regulations. Financial eligibility is determined by the DHS income maintenance worker. No client financial participation is allowed except as provided under Medicaid regulation.

Specific diagnosis are required for each service as indicated in below. The required diagnosis may be the primary or secondary diagnosis.

Services: ICF-MR – ID, DD
HCBS-ID Services - ID
- Transportation
- Home Health Aide
- Respite
- Home & Vehicle Modification
- Supported Community Living
- Consumer Directed Attendant Care
- Consumer Choice Option
- Adult Day Care
- Pre-Vocational Services
- Supported Employment
- Day Habilitation
- Nursing Care Service
- Personal Emergency Response
- Interim Medical Monitoring & Treatment
- Day Camp

Habilitation Services – CMI
- Case Management
- Home-Based Habilitation
- Supported Employment
- Day Habilitation
- Pre-Vocational Services

Targeted Case Management – ID, DD, CMI
Other Enhanced Services: Day Treatment/Partial Hospital - CMI

<u>100% COUNTY FUNDED SERVICES</u>
These are services with county funding for 100% of the cost. These services are not mandated except as provided under the individual county's Management Plan. All local eligibility criteria must be met.

These are generally services not available under Medicaid or are provided to non-Medicaid eligible persons. In some instances, persons who are awaiting approval of Medicaid eligibility may be considered for funding for these services until such time that Medicaid service funding becomes available.

Specific diagnosis are required for each service. The required diagnosis may be the primary or secondary diagnosis. The required diagnosis is indicated ibelow.

Statewide Services:
- Outpatient Mental Health – MI, CMI
- Vocational Services: Sheltered Workshop, ID
- Case/Service Management (100% County) – ID, CMI
- Residential Services: RCF, RCF-MR, RCF-PMI, ICF-PMI – ID, CMI

Other services provided by some, but not all, counties: Supported Community Living, Transportation, Prescription Medication, Payee, Housing Subsidy, etc.

ISSUES FOR ID CORE SERVICES

1. The Medicaid services available through the ID Waiver in combination with ICF-MR and Targeted Case Management provide a rich array of services for persons with Intellectual Disabilities who are Medicaid eligible.

2. Most people accessing this service system with Intellectual Disabilities, will already have a disability determination from Social Security and will meet the 300% financial eligibility for HCBS ID Waiver services. Therefore, the majority of these persons will be eligible for the Medicaid services.

3. The following instances are outside of Medicaid eligibility and system recommendations should be developed:

   a. Services not available under Medicaid (primarily sheltered workshop)

   b. Persons applying to Social Security who do not yet have a disability determination and are not Medicaid eligible. (disability and Medicaid approval should not take a significant amount of time with this disability)

   c. Need for immediate services (Waiver services require a period of time to initiate)

   d. Waiting time while on the statewide waiting list .

4. Need for an increased capacity to provide services to persons with serious behavioral issues (often co-occurring ID/CMI).

   a. Admission to the State Resource Centers is a lengthy process due to lack of available beds.

   b. Consideration should be given to defining the State Resource Centers as specialized ICF-MRs with continued stay criteria to be implemented over an established time frame including movement of some current residents to community based ICF-MR or ID Waiver.

   c. Community ICF-MR and ID Waiver services should be explored to determine a method for creating and funding more intense levels of behavioral services and/or other specialized needs.

5. Support the value of “productive activity” as a quality of life issue through assuring a choice of a variety of settings and activities/services.

   a. Continue to increase Supported Employment as an available “productive activity”.

   b. Review funding of enclaves and assure an effective bridge into supported employment. Enclaves should be fiscally viable with two to three persons served and move away from requiring six to eight persons in an enclave setting.

c. Assure that Pre-Voc is not limited beyond federal requirements.

d. Maintain Sheltered Workshop as a part of the array of "productive activity" services.

e. Determine what types of "productive activity" can be made available in the Day Habilitation program (ex: volunteer activities).

6. Strengthen/combine Targeted Case Management and local service/care management to provide a Local Service Access process including a physical presence in each county (at least on a part time basis).

   a. The current TCM system should be reviewed to eliminate the excessive paperwork to provide a more hands on, person involved service.

   b. The Local Service Access process should provide TCM for Medicaid eligible persons and a similar Care Management service for non-Medicaid eligible persons.

   c. The Local Service Access staff should be experienced in the disability areas and skilled in providing management of the system for persons requesting service. The staff should be provided on-going development to assure understanding of emerging issues, trends and thinking in provision of disability services.

   d. Supervision of the Local Service Access process should include both administrative and clinical supervision and be provided by a skilled practitioner.

   e. The management of the local service array should be vested with the Supervisor of this local process. The supervisor should maintain the local liaison functions with the disability provider community, other human service providers, law enforcement, court officials, etc.

   f. The Local Service Access process should provide the gatekeeper function for the system, including service authorization decisions relating to all managed funding sources. (hopefully Medicaid waiver, ICF-MR, TCM, and county funding)
      1. Recommended authorization made by the Case Manager
      2. Review and approval by the Supervisor.

   g. The Local Service Access Process should provide:
      1. Eligibility determination: diagnostic, financial, residency
      2. Assessment of service need
      3. Care planning
      4. Referral to provider services
      5. Review and authorization of services
      6. Ongoing monitoring of services